TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Wausau Underwriters Insurance

MFDR Tracking Number
M4-16-2770-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $5,321.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Doctors Hospital at Renaissance has been appropriately reimbursed for services rendered to (claimant) for the date(s) of service."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6 – 13, 2015	Outpatient hospital services	$5,321.52	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out Division guidelines regarding preauthorization.
3. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - MOPS – Services reduced to the outpatient perspective payment system
    - MSIN – This is a packaged item services or procedures included in the APC rate but not paid separately
    - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
    - X170 – Pre authorization was required but not requested for this service per DWC rule 134 600

- U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Is the carrier's denial supported?
2. What is the Medicare payment rule?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied procedure code 63042 as X710 – "Pre authorization was required but not requested for this service per DWC Rule 134.600." 28 Texas Administrative Code 134.600 (p) "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;" Review of the submitted documentation finds a "Pre-Cert" request dated September 17, 2015 with CPT: 63047 as the only requested service. The carrier's denial is supported no additional payment is recommended.

2. The services in dispute are for Outpatient Hospital Services with dates of service October 6, 2015 through October 13, 2015. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

The Medicare facility specific reimbursement amount is explained at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf as:

> *"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.*
>
> *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent)* ***is further adjusted by the hospital wage index*** *for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:"*

The facility specific reimbursement amount is calculated as follows:

Payment rate found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html **Geographic adjustment**

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
63047	0208	T	$4,113.17	$4,113.17 x 60% = $2,467.90	0.8197 x $2,467.90 = $2,022.94	$4,113.17 x 40% = $1,645.27	$2,022.94 + $1,645.27 = $3,668.21

The remaining services in dispute are reviewed as follows:

- Procedure code 80048, date of service October 6, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 82962, date of service October 12, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 83036, date of service October 12, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 82962, date of service October 13, 2015, has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85027, date of service October 6, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 81001, date of service October 8, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 88304, date of service October 12, 2015, has status indicator Q1 denoting STVX-packaged codes. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 88311, date of service October 12, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 72020, date of service October 12, 2015, has status indicator Q1 denoting STVX-packaged codes. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J1100 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J0330 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2001 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2765 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 93005, date of service October 6, 2015, has status indicator Q1 denoting STVX-packaged code. This code may be separately payable only if no other such procedures are reported for the same date.

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

10.1.1 - Payment Status Indicators

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

10.2 - APC Payment Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

3. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code 63042 has status indicator T denoting a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. The total Medicare facility specific reimbursement amount for this line is $3,668.21. This amount multiplied by 200% yields a MAR of $7,336.42.
- Procedure code 97001, date of service October 13, 2015, has status indicator A denoting services paid under a fee schedule or payment system other than OPPS. 28 Texas Administrative Code §134.203 (c) states, “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is(date of service yearly conversion factor). The MAR is calculated as follows, (DWC

Conversion Factor / Medicare Conversion Factor) x Medicare Allowable or 56.2/35.9335 x 73.06 = $114.26.

4. The total allowable reimbursement for the services in dispute is $7,450.68. This amount less the amount previously paid by the insurance carrier of $7,621.78 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.